METHODS AND STANDARDS FOR ESTABLISHING PROSPECTIVE PAYMENT RATES - INPATIENT HOSPITAL SERVICES

PAYMENT METHODS FOR HOSPITALS

Effective December 15, 1989 (unless otherwise specified in this plan) the following prospective payment method shall apply to all Colorado participating hospitals except those specialty hospitals and units within general acute care hospitals designated by the State agency as exempt.

Definitions:

1. Diagnosis Related Group (DRG): A patient classification system that reflects clinically cohesive groupings of inpatient hospitalizations utilizing similar hospital resources. Colorado will adopt the Medicare classification system as a base for the DRG payment system. The State Agency has the authority to make changes to the Medicare grouper methodology to address issues specific to Medicaid.

2. Principal Diagnosis: The diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

3. Relative Weight: A numerical value which reflects the relative resource consumption for the DRG to which it is assigned. A specific Colorado case mix index is calculated by adding the relative weights of all DRG cases for a specific period of time and dividing by the total number of cases.

   Modifications to these relative weights will be made when needed. Relative weights are intended to be cost effective, and based upon Colorado data as available. The State Agency shall rescale DRG weights, when it determines it is necessary, to ensure payments reasonably reflect the average cost of claims for each DRG. Criteria for establishing new relative weights will include, but not be limited to, changes in the following: new medical technology (including associated capital equipment costs), practice patterns, changes in grouper methodology, and other changes in hospital cost that may impact upon a specific DRG relative weight. Any changes shall be made with input from the DRG Advisory Committee.

4. Hospital Peer Groups: A grouping of hospitals for the purpose of cost comparison and determination of efficiency and economy. The peer groups are defined as follows:

   A. Pediatric Specialty Hospitals: all hospitals providing care exclusively to pediatric populations.

   B. Rehabilitation and Specialty-Acute Hospitals: all hospitals providing rehabilitation or specialty-acute care (hospitals with average lengths of stay greater than 25 days).

   C. Rural Hospitals: Colorado Hospitals not located within a federally designated Metropolitan Statistical Area (MSA).

   D. Other Urban Hospitals: all Colorado hospitals in MSA's except for those in the Denver MSA. Also included would be the Rural Referral Centers in Colorado, as defined by HCFA. (SSAS, 1886 (d) (5) (c) (I); Reg. 412.90 (c) and 412.96).

   E. Denver Metro Urban Hospitals: all hospitals located within the Denver MSA.

   Facilities which do not fall into the peer groups described in a. or b. will default to the peer groups described in c. through e. based on geographic location.

5. Base Rate: A dollar figure which is based on the average historical Medicaid total cost per discharge for each facility. Data used to calculate the base rate is derived from the audited Medicare/Medicaid cost report.

   The calculated cost per discharge derived from the cost report data is inflated using the HCFA Market Basket Index . A percentage of the costs of the Routine, Ancillary, Capital, Medical Education and Physician cost centers to the total cost is then calculated and those percentages are applied to the inflated cost per discharge. The cost per discharge in the five cost centers is adjusted for each facility's Colorado Medicaid case mix, then totaled to arrive at the facility's base rate. The facility's base rate is further modified to reflect efficiency and economy of operation by limiting payment made to each facility at the lower of their actual cost for each cost center or a capped amount for each cost center. These caps are determined by arraying the costs of all facilities within each peer group by cost center and determining the appropriate percentile of facilities which will have their costs covered. (Note: Hospital based physician reimbursement is cited in 42 CFR 405.465. Only one

prospective payment facility in Colorado is able, under statue, to employ hospital-based physicians directly. Physician costs for this facility will be based upon Medicare/Medicaid audited cost data. These costs are capped based on the facility's average cap to cost ratio as follows: (ancillary cap + routine cap + capital cap) ÷ (ancillary cost + routine cost + capital cost)) For each peer group, these percentiles for the Routine, Ancillary, Capital and Medical Education Cost Center are as follows:

A. Denver Metro Urban Hospital:
Routine - 60th percentile
Ancillary - 55th percentile
Capital - 50th percentile
Medical Education - 100th Percentile

B. Other Urban Hospitals:
Routine - 65th percentile
Ancillary - 60th percentile
Capital - 50th percentile
Medical Education - 100th percentile

C. Rural Hospitals
Routine - 70th percentile
Ancillary - 65th percentile
Capital - 50th percentile
Medical Education - 100th percentile

Due to the outliers that exist when arraying the costs per discharge for rural facilities, Colorado shall exclude the top six and the bottom six facilities in the array before computing the caps for the Routine, Ancillary, Capital and Medical Education cost centers. No payment to rural hospitals shall be less than the payment calculated for the least costly hospital after the bottom six have been eliminated from the array. Outliers have not been excluded from cost calculation when arraying costs in non-rural facilities.

D. Pediatric Specialty Hospitals

The cap for the Medical Education cost center for pediatric specialty hospitals will be set at 100 percent. The caps for the three remaining cost centers will be set based on the proportion of actual cost in each of these cost centers from the most recently audited cost report. In subsequent rebasing years, the cap for the routine, ancillary, and capital cost centers shall be adjusted to maintain a stable relationship to the caps for each cost center in the Denver metro urban hospital peer group.

E. Rehabilitation/Specialty-Acute Hospitals

Routine - 60th percentile
Ancillary - 55th percentile
Capital - 50th percentile
Medical education - 100th percentile

6. Exempt hospitals are those hospitals which are designated by the Department to be exempt from the DRG-based prospective payment system. The Department may designate facilities as exempt or non-exempt providers. Non-exempt providers shall be reimbursed using the DRG-based prospective payment system (PPS). Exempt hospitals will be paid a per diem for inpatient hospital services

7. Teaching Hospital Allocation: Effective October 1, 1994 hospitals shall qualify for additional payment when they meet the criteria for being a Teaching Hospital.

A. A hospital qualifies a Major Teaching Hospital when its Medicaid days combined with indigent care days (days of care provided under Colorado's Indigent Care Program) equal or exceed 30 percent of their total patient days for the prior state fiscal year, or the most recent year for which data are available.

A Major Teaching Hospital is defined as a Colorado hospital which meets the following criteria:

1. Maintains a minimum of 110 total Intern and Resident F.T.E.'s.

2. Maintains a minimum ratio of .30 Intern and Resident F.T.E.'s per licensed bed.

3. Meets the Department's eligibility requirement for disproportionate share payment.

The additional major teaching payment is calculated as follows:
MTHR = ((ICD+MD)/TPD) x MIAF

Where:

MTHR = Major Teaching Hospital Rate
ICD =Indigent Care Days
MD = Medicaid Days
TPD =Total Patient Days
MIAF = Medically Indigent Adjustment Factor

To further clarify this formula the State describes the MIAF as follows:

It is the State's intention to pay no hospital a Major Teaching Hospital Allocation that would cause a qualifying hospital to receive an average payment per Medicaid discharge which would exceed the facility's Medicare payment. The MIAF is a number which when multiplied by the numerical quotient derived from

((MD+ICD)/TPD) results in a rate which permits the State to pay a Major Teaching Hospital Allocation at a payment amount which, by design, will not exceed each individual facility's Medicare payment (applied by the State as an individual facility upper limit). The MIAF is derived from calculation of the amount determined by subtracting the average Medicaid payment per case from the average Medicare payment per case for the calculation period, and multiplying this amount by the number of Medicaid patient discharges occurring during that period.

The MIAF is based on the facility's Intern and Residents FTEs:

Intern and Resident FTEs	MIAF - 7/1/93 to 6/30/94	7/1/94 to 6/30/95
110 TO 150	.7209	.5683
151 TO 190	.3301	.9352

Payment calculation for hospitals which qualify for the additional Major Teaching Hospital payment shall be as follows:

1. Based upon data available at the beginning of each fiscal year, Colorado shall determine each hospital's ICD, MD and TPD. ICD will be extracted from the most recent available Colorado Indigent Care Program Interim Report to the Colorado General Assembly, submitted by the University of Colorado Health Sciences Center. MD and TPD will be extracted from the most recent available Colorado Hospital Association annual Data Bank information subject to validation through use of data from the Department and the Colorado Foundation for Medical Care. In addition, each hospital's Medicaid payment for the previous fiscal year shall be estimated.

2. Multiply the Medicaid payment by the calculated MTHR to determine the additional major teaching hospital payment.

3. Payment shall be made monthly.

B. A hospital qualifies as a Teaching Hospital when it has a Family Medicine Program meeting the Medicaid inpatient utilization rate formula. These Family Medicine programs must be recognized by the Family Medicine Commission and are defined

as those programs having at least 10 residents and interns. The Family Medicine program must be affiliated with a Medicaid participating Hospital that has a Medicaid utilization rate of at least one percent. If a Family Medicine program is affiliated with a facility that participates in the Major Teaching Hospital program, it is not eligible for this program unless the facility is a university hospital. Family Medicine programs meeting these criteria shall be eligible for an additional primary care payment adjustment as follows:

For each program which qualifies under this section, these amounts will be calculated based upon historical data and paid in 12 equal monthly installments. In each State fiscal year, the annual payment for each Family Medicine Residency Program will be $213,195. Effective July 1, 1999, the annual payment for each Family Medicine Residency Training Program will be $228,379. The annual payment shall change based on requests for annual inflation increases by the Commission on Family Medicine, subject to approval by the General Assembly.

8. Disproportionate Share Hospital Adjustment:

A. Federal regulations require that hospitals which provide services to a disproportionate share of Medicaid recipients, shall receive an additional payment amount to be based upon the following minimum criteria:

1. Have a Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State, or a low income utilization rate that exceeds 25 percent; and

2. A hospital must have at least two obstetricians with staff privileges at the hospital who agree to provide obstetric services to individuals entitled to such services under the State Plan. In the case where a hospital is located in a rural area, (that is an area outside of a Metropolitan Statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

3. Number 2 above does not apply to a hospital in which:

a. The inpatients are predominantly under 18 years of age; or

b. Does not offer non-emergency obstetric services as of December 21, 1987.

The Medicaid inpatient utilization rate for a hospital shall be computed as the total number of Medicaid inpatient days for a hospital in a cost reporting period, divided by the total number of inpatient days in the same period.

For purposes of paragraph 8.A.1., the term "low income utilization rate" means, for a hospital, the sum of:

(A) The fraction (expressed as a percentage)

(i) The numerator of which is the sum (for a period) of (I) total revenues paid the hospital for patient services under a State Plan under this title and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) The denominator of which is the total amount of revenues of the hospital for patient service (including the amount of such cash subsidies) in the period; and

(B) The fraction (expressed as a percentage)

(i) The numerator of which is the total amount of the hospital's charge for inpatient hospital services which are attributable to charity care in a period less the portion of any cash subsidies described in clause (i) (II) of subparagraph (A) (of section 1923 of the Social Security Act) in the period reasonably attributable to inpatient hospital services. and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approach under this title).

B. Colorado determination of Individual Hospital Disproportionate Payment Adjustment.

Effective January 1, 1991, hospitals deemed eligible for minimum disproportionate share payment will receive the following payment adjustment:

1. Hospitals with a Medicaid inpatient utilization rate in excess of 1 standard deviation above the State's mean Medicaid patient day utilization rate will receive a minimum of a 2 1/2% increase in the calculated base or per diem rate. To pay hospitals proportionally for their level of Medicaid inpatient

utilization the following schedule will be applied to each specific Medicaid utilization rate:

STANDARD DEVIATION LEVEL ABOVE MEAN	INCREASE IN MEDICAID PAYMENT
1.0 – 1.19	2.5%
1.2 – 1.39	3.0%
1.4 - 1.59	3.5%
1.6 - 1.79	4.0%
1.8 - 1.99	4.5%
2.0 - 2.19	5.0%
2.2 - 2.39	5.5%
2.4 - 2.59	6.0%
2.6 - 2.79	6.5%
2.8 - 2.99	7.0%
3.0 - 3.19	7.5%
3.2 - 3.39	8.0%
3.4 - 3.59	8.5%
3.6 - 3.79	9.0%
3.8 - 3.99	9.5%
4.0 +	10.0%

2. Hospitals qualifying under the low-income utilization rate formula, but not under the Medicaid inpatient utilization rate formula, will receive at a minimum 0.1% increase in payment. To pay hospitals proportionately for their level of low-income utilization, the following schedule will be applied to each specific low-income utilization rate:

LOW-INCOME UTILIZATION PERCENT	INCREASE IN MEDICAID PAYMENT
25% - 49.99%	0.10%
50% - 74.99%	0.15%
75% - 99.99%	0.20%
100% +	0.25%